Kindergarten Oral Health Assessment Form

California law (Education Code Section 49452.8) says every child enrolled in kindergarten in a public school, and any child enrolled in first grade who did not attend public school the previous year, must have a dental check-up (assessment). It should be turned in at the beginning of the school year. A California licensed dental professional must do the check-up and fill out Sections 2 and 3 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Sections 2 and 3. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy, and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California’s children.

Section 1: Child’s Information (Filled out by parent or guardian)

<table>
<thead>
<tr>
<th>Child’s First Name:</th>
<th>Last Name:</th>
<th>Middle Initial:</th>
<th>Child’s Birth Date: MM – DD – YYYY</th>
</tr>
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<tbody>
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Address:                                                                                                          Zip Code:                  Apt.:
City:                                                                                                              

School Name:                                                                                                       Teacher:                   

Grade:                                                                                                              Year child starts kindergarten: YYYY

Parent/Guardian First Name:                                                                                         Parent/Guardian Last Name:  

Child’s Gender:  

- [ ] Boy  
- [ ] Girl  
- [ ] Nonbinary

Child’s Race/Ethnicity:

- [ ] White  
- [ ] Black/African American  
- [ ] Hispanic/Latino  
- [ ] Asian  
- [ ] Native Hawaiian/Pacific Islander  
- [ ] Native American  
- [ ] Multi-racial  
- [ ] Unknown  
- [ ] Other (please specify)

Dental home information

Does your child visit the same dentist twice a year (once every 6 months?)

- [ ] Yes  
- [ ] No

If no to above, does your child visit the dentist once a year?

- [ ] Yes  
- [ ] No

Does your child have dental insurance?  

- [ ] Yes  
- [ ] No

Does your child have Health Plan of San Mateo Dental (HPSM Dental) insurance?  

- [ ] Yes  
- [ ] No

Dental clinic name:  

Dental clinic address:  

Dentist name:  

Dentist phone number:  

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Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Caries experience is both past treatment (e.g., fillings, crowns) and/or untreated decay at the present time (e.g., untreated cavities).

<table>
<thead>
<tr>
<th>INCORRECT ENTRIES</th>
<th>CORRECT ENTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Untreated decay</td>
<td>Untreated decay</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

Section 2: Oral health screening assessment

Assessment Date: MM – DD – YYYY
Location:
- Dental office
- School
- Other:

Untreated Decay (Visible Decay)
- Yes (If yes, caries experience is automatically also Yes)
- No

Caries Experience (untreated decay and/or fillings present - see examples above)
- Yes
- No

Treatment Urgency:
- Early dental care recommended (Check all that apply):
  - Caries without pain or infection
  - Child would benefit from further evaluation
  - Child would benefit from sealants
- Urgent care needed (Check all that apply):
  - Pain
  - Swelling
  - Infection
  - Soft tissue lesions

Licensed Dental Professional Signature CA License Number Date

Section 3: Follow-up to Urgent Care (Filled out by dental office or entity responsible for follow up)

Parent notified that child has urgent dental care need on: MM – DD – YYYY

A follow-up appointment for this child has been scheduled for: MM – DD – YYYY

Did child receive needed treatment?
- Yes
- No (If no, entity responsible for follow-up is encouraged to check back in with parent)
- I don’t know

The law states schools must keep student health information private. Your child’s name will not be part of any report as a result of this law. This information may only be used for purposes related to your child’s health. If you have questions, please call your school.

Return form to the school no later than by the end of your child’s first school year. Original to be kept in child’s school record.